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MEDICAID MEMO

TO: Case Management Providers for Individual and Family Developmental Disabilities Support (IFDDS) Waiver

FROM: Gregg A. Pane, MD, MPA, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 10/1/2010

SUBJECT: Changes to Required Documentation Submitted to KePRO for IFDDS Waiver Services – ***Effective November 1, 2010***

The purpose of this memorandum is to notify providers that submit requests to Keystone Peer Review Organization (KePRO) for Individual and Family Developmental Disabilities Support (DD) Waiver of changes to the documentation required for certain services. These changes are intended to improve utilization and quality outcomes.

Effective November 1, 2010, the Department of Medical Assistance Services (DMAS) will require that providers submit clinical information to KePRO for the following services. The clinical information requirements are listed within this memo.

Procedure Code/Service Definition	Procedure Code/Service Definition
H2014 – In Home Residential Services	T1019 – Agency Directed Personal Care
S5126 – Consumer Directed Personal Care	T1005 – Agency Directed Respite
S5150 – Consumer Directed Respite	S5165 – Environmental Modifications
99199, U4 – Environmental Modifications, Maintenance	T1999 – Assistive Technology
T1999, U4 – Assistive Technology, Maintenance	S5111 – Family Caregiver Training

Required Documentation to be Submitted to KePRO

For dates of service on or after November 1, 2010, providers are to submit the following information to KePRO when requesting authorization. This documentation is in addition to information currently being submitted for review.

1. *In-Home Residential Services (H2014)* – Documentation must include the name(s) of the In-Home Residential Support direct care staff (clinician) and the relationship to the individual. This is not the agency provider name. This does not apply when requesting initial SA for waiver enrollment.

2. *Agency Directed Personal Care (T1019) and Consumer Directed Personal Care (S5126)* – When an individual is readmitted after discharge or transferred to a new provider, documentation of a new assessment (DMAS-99) must be submitted with the service authorization request. The new assessment must be signed and dated on or before the new start of care date. Service will not be approved prior to the date of the signature on the DMAS 99. When the individual is readmitted or transfers to another provider and the hours are not changing and remain within the cap, there is no need to submit a plan of care (DMAS 97A/B), however the date the new plan of care was completed must be documented with the Service Authorization (SA) submission to KePRO. If there is an increase or decrease in the amount of hours from the prior agency, a new DMAS 97A/B and justification for the change in hours is required. Although the revised plan of care is not required to submit for SA, it is required in the individual's record at the agency site for audit purposes.

   Additionally, for both service delivery models agency directed and consumer directed services, documentation must include the name of the personal care aide/attendant and the name of the unpaid primary caregiver. Aides/Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are directing the individuals care. Names of direct care staff are not needed when requesting initial SA for waiver enrollment.

3. *Agency Directed Respite (T1005) and Consumer Directed Respite (S5150)* – Documentation must include names of all other family members over the age of 18 who live under the same roof as the individual receiving services. Respite services cannot be approved when services are rendered by family members who live in the same home with the individual. For transfers, a DMAS 225 or notice of discharge from the previous case manager and/or service provider with the last date of services provided must be submitted to KePRO in order for the SA to be closed. When discharge information is not received from the initial case manager/ service provider, before the second service provider submits the admission request, KePRO will close the initial providers' SA immediately prior to the second service provider's first date of service and will process the second provider's request.

   Additionally, for consumer directed services, documentation must include the name of the attendant and the name of the unpaid primary caregiver. Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are directing the individuals care. Names of direct care staff are not needed when requesting initial SA for waiver enrollment.

4. *Environmental Modifications (S5165), Environmental Modifications, Maintenance (99199, U4), Assistive Technology (T1999), and Assistive Technology, Maintenance (T1999, U4)* – Any change in costs to an existing SA must be approved by DMAS on the plan of care before submitting to KePRO. The documentation submitted to KePRO must match the name of the item and/or modification as well as the total cost of the item as listed on the DMAS approved plan of care. The dates requested must fall within the dates on the plan of care authorized by DMAS. Environmental Modifications (EM), Assistive Technology (AT), Therapeutic Consultation, PERS, Family Caregiver Training and Crisis Stabilization/ Supervision are not stand alone services This means the individual must be receiving case management services in addition to having at least one other qualifying waiver service in place prior to requesting this service.

5. *Family Caregiver Training (S5111)* – This is not a stand alone service. In order to receive this service, the enrolled individual must also receive at least one of the qualifying services. Environmental Modifications (EM), Assistive Technology (AT), Therapeutic Consultation, PERS, Family Caregiver Training and Crisis Stabilization/ Supervision are not stand alone services. This means the individual must be receiving case management services in addition to having at least one other qualifying waiver service in place prior to requesting this service. Documentation submitted to KePRO must include the name of the person who will

receive the training and their relationship to the enrolled individual. The name and title of the professional providing the training is required, and they must have the appropriate licensure or certification for their profession to practice in the Commonwealth of Virginia. The Family Caregiver Trainer must be one of the following licensed professionals: occupational therapist, physical therapist, speech language pathologist, physician, psychologist, LCSW, LPC, RN and Special Education Teachers. Additionally, the Family/Caregiver Trainer must be enrolled as a DMAS provider.

Revisions to the Plan of Care

All revisions to the Plan of Care must be approved by DMAS prior to requesting services through KePRO. The plans of care are submitted to KePRO to reference when service requests are submitted. If a service has been removed from the revised plan, it is the case manager's responsibility to submit a discharge request to KePRO to end the service(s). Should providers continue to bill after the service is removed from the revised plan of care, the claims paid are subject to full retraction on post payment review.

Timeframes Changing for Responding to Pends

Effective September 1, 2010 the provider will have five (5) business days to respond to a request that has been pended for additional information from KePRO. If the provider does not respond within this timeframe, the information that was initially submitted will be processed and a final determination made. A postcard was sent to providers in August, 2010 notifying them of this change.

Electronic Submission of Service Authorization Requests via iEXCHANGE

Effective October 1, 2010, all information submitted to KePRO for review of a SA request, changes to existing cases, and additional information is strongly encouraged to be submitted via iEXCHANGE™. Virginia Medicaid providers have been successfully submitting requests to KePRO via iEXCHANGE™ since 2006. In 2010, the rate of iEXCHANGE™ use has significantly increased. There is a high level of satisfaction with this submission method, and few problems have been reported.

Registration is required to access and use iEXCHANGE™. You must have an iEXCHANGE™ account before submitting information through iEXCHANGE™. To register for an iEXCHANGE™ account, please have the following information ready to enter on the registration site: 1) Remittance Advice (RA) payment address ("Pay To" address); **and either** 2) 1099 total amount (current year to date total); **or** 3) last Remittance date (last payment date). It may be necessary to contact your agency's Business Office or Billing Department for this information. You may register at https://dmas.kepro.org/. Simply click on the "First time registration for iEXCHANGE" button and you will be prompted through the registration process and assigned a password after registering. Your password will be sent via e-mail and may take up to ten (10) business days to receive after completing the registration process. Early registration is strongly encouraged; it is strongly recommended that you register during September 2010 in order for providers to get passwords and set up accounts prior to the implementation date. This will ensure that you will be able to access and use iEXCHANGE™ by October 1, 2010. Once you receive your password, you will be able to set up your account, specify users within your organization, and customize your account. Early registration is encouraged, as all timely submission requirements remain in effect after October 1, 2010. Providers who have registered for iEXCHANGE™ use for the other services (e.g. outpatient requests) do not have to register a second time to submit waiver authorization requests.

iEXCHANGE™ Training and Assistance

KePRO will offer frequent trainings regarding iEXCHANGE™ account set-up and information on how to submit requests via iEXCHANGE™. Please visit KePRO's website at https://dmas.kepro.org/ for specific training information/schedules and a directory of available trainings that can be viewed at your convenience, including how

to navigate the iEXCHANGE™ system. Click on the *Training* tab where you will see a link to *Scheduled Training Live and Recorded*, as well as a listing by review type of all training documents available for reading and download.

To attend a scheduled web based training:
Go to the KePRO website, https://dmas.kepro.org , click on the *Training* tab and you will see the *Scheduled Training Live and Recorded* link. This will take you to the live and recorded sessions.

Registration is not required to attend KePRO's live web presentations, but space is limited to 100 attendees. All recorded training will be available to you to view at your convenience at any time.

KePRO Contact Information	**DMAS Contact Information**
E-Mail: ProviderIssues@kepro.org **Customer Service Assistance: Toll Free** 1-888-VAPAUTH (1-888-827-2884) **Local Phone:** (804) 622-8900 http://dmas.kepro.org/	**E-Mail:** PAUR06@dmas.virginia.gov **PAUR Unit Phone:** 804-225-3536 **DMAS Provider Helpline:** 800-552-8627 (in-state long distance) 804-786-6273 (local and out-of-state) www.dmas.virginia.gov

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the ACS Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 A.M. to 5:00 P.M. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.